STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: UTAH

CASE MANAGEMENT SERVICES

A. Target Group:

Case management services are provided to a woman with a medically verifiable pregnancy who is a Medicaid client or who meets the financial requirement for presumptive eligibility to receive ambulatory prenatal care services provided by a provider that is eligible for payment under the State Plan.

The Case Manager for this program will be known as the Perinatal Care Coordinator.

B. Areas of State in which services will be provided:

X Entire State.

Only in the following geographic areas. Authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide.

C. Comparability of Services

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the act.

State/Territory: Utah

D. Definition of Services:

Perinatal care coordination is the process of planning and coordinating care and services to meet individual needs and maximize access to necessary medical, psychosocial, nutritional, educational and other services for the pregnant woman.

Perinatal care coordination services are available to the pregnant woman throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

This coordination process requires the skill and expertise of professionals who have broad knowledge of perinatal care, interviewing and assessment techniques, alternative community resources, and referral systems required to develop an individual service plan.

The Perinatal Care Coordinator serves as a liaison between clients and individuals or agencies involved in providing care, as a contact person for the client and family, as a resource to prepare and counsel the client regarding essential services that are determined necessary and scheduled for the client.

Needs of pregnant women are individual and influenced by varying medical, personal, socioeconomic and psychosocial factors. A plan of care with intervention to meet identified needs or resolve problems may be indicated on a limited, intermediate, or comprehensive basis. The initial assessment made by the Perinatal Care Coordinator will be the basis for determining the level of care and the extent of coordination and monitoring necessary for each individual.

Monitoring of the individual plan of services by the Perinatal Care Coordinator is essential to minimize fragmentation of care, reduce barriers, link clients with appropriate service, and assure that services are provided consistent with optimal perinatal care standards.

Monitoring involves direct contact with the client through clinic, home visits, or telephone contact. Monitoring includes a contact resulting in assessment, planning of care and services, and re-evaluation of the plan of care. Monitoring may also include consultation with care providers to assess the need for further follow-up or coordination and arrangement of necessary services.

The number, duration, scope and interval between contacts will vary among clients and even across one client's pregnancy. At a minimum, contacts, including telephone contacts with the client, must include: assessment and documentation of current physical, psychosocial, socioeconomic, and nutritional status. Follow up on the outcome of previous referrals must be included along with documentation of any referrals arranged for additional services. Anticipatory guidance regarding pregnancy and parenting must also be documented.

(Definition of Service cont'd)

A record of contacts made with the client or with providers on behalf of the client, and services arranged or provided by the Perinatal Care Coordinator must be documented and maintained in the medical record, and must include:

Name of recipient,
Date of service,
Name of provider agency and person providing the service,
Place of service,
Nature and extent of the service, including outcome of the contact,
Intake assessment,
Individualized care plan (including risk factors and proposed referrals to deal with those risk factors), and
Changes to care plans as indicated by contact with client or providers.

Providers of perinatal care coordination services are expected to meet the following qualifications:

Registered Nurse -- Licensed in accordance with the Nurse Practice Act of the State of Utah.

Certified Registered Nurse Midwife -- Licensed in accordance with the Certified Nurse Midwifery Practice Act of the State of Utah.

Certified Family Nurse Practitioner -- Licensed in accordance with the Nurse Practice Act of the State of Utah.

Social Service Worker (SSW) -- With a minimum of a bachelor's degree in social work, and licensed according to the Social Work Licensing Act of the State of Utah.

Licensed Certified Social Worker (LCSW) -- With a minimum of a master's degree in social work, and licensed according to the Social Work Licensing Act of the State of Utah.

Health Educator -- Bachelor's degree in health education with a minimum of three years experience, at least one of which must be in a medical setting.

Health Educator -- Master's degree with a minimum of one year of experience working in a medical setting or with pregnant women.

Certified Health Education Specialist -- With a minimum of a bachelor's degree and a certificate showing completion of a certification examination in health education.

Licensed Practical Nurse -- Licensed in accordance with the Nurse Practice Act of the State of Utah. Must have additional training and experience to meet the expectations of the Perinatal Care Coordinator and must work under the supervision of a registered nurse.

(Definition of Services cont'd)

Provided by:	Perinatal Care Coordinator who is an enrolled Medicaid provider
Billed by:	Perinatal Care Coordinator using a HCFA 1500 Claim Form
Billing Code:	Y7000 Perinatal Care Coordination

E. Qualification of Providers:

Recipients will have the free choice of any enrolled qualified Case Manager (Perinatal Care Coordinator). Qualified Case Managers are registered nurses, certified nurse midwives, certified family nurse practitioners, licensed social service workers, certified social workers, health educators or licensed practical nurses licensed under the authority of Title 58 (Occupational and Professional Licensing) of the Utah Code Annotated, 1953 as amended, practicing within the scope of their licensure, and recognized by the Utah Department of Health, Division of Health Care Financing and the Division of Family Health Services prenatal program.

The Case Manager (Perinatal Care Coordinator) can be employed by a physician who is a Medicaid provider, or employed by a Qualified Provider of Presumptive Eligibility services.

F. The State assures that the provision of Case Management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of Case Management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for Case Management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: UTAH

CASE MANAGEMENT SERVICES

A. Target Group

Targeted case management services are provided to chronically mentally ill Medicaid eligibles who are not otherwise eligible for targeted case management service as part of another approved target group. The need for case management service will be identified by a physician or other mental health professional in the recipient's treatment plan for mental health clinic, outpatient hospital, or physician service.

B. Areas of State in Which Services Will Be Provided:

/x/ Entire State.

/ / Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide:

C. Comparability of Services

/ / Services are provided in accordance with section 1902(a)(10)(B) of the Act.

/x/ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: UTAH

D. Definition of Services:

Targeted case management services are a set of planning, coordinating, and monitoring activities that assist individuals in the target group to access needed medical, social, educational, and other services and thereby promote the individual's ability to function independently and successfully in the community.

1. Covered case management activities include:

   a. assessment of the recipient's potential strengths, resources, and needs and the development of a comprehensive service plan in conjunction with the recipient, family, and other significant individuals;

   b. advocating for, and linking the recipient with, services identified in the service plan such as mental health, housing, medical, social, or nutritional services;

   c. assisting the recipient to acquire necessary independent living skills such as compliance with the prescribed medication regimen, preparing for job interviews, managing money; and assisting the recipient during acute crisis episodes to ensure the provision of the most appropriate cost-effective service;

   d. coordinating the delivery of needed service and monitoring to assure the appropriateness and quality of services delivered including coordinating with the hospital and nursing facility discharge planner in the 30-day period prior to the patient's discharge into the community. (This is the only case management service provided to hospital or nursing facility inpatients and is limited to a maximum of five hours per patient per inpatient hospitalization.) In addition, case management services will not be provided to individuals between the ages of 22 and 64 who are inpatients in institutions for mental disease;

   e. monitoring to assess the recipient's progress and continued need for service.

2. Non-covered services include:

   a. medical or other treatment services;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: UTAH

b. outreach to individuals who may or may not be eligible for case management services;

c. consultation with other mental health staff in the same agency.

E. Qualifications of Providers:

Qualified case managers include:

1. licensed mental health professionals (psychologist, certified or clinical social workers, social service workers, registered nurse with training or experience in psychiatric nursing, marriage and family therapist) employed by comprehensive community mental health clinics; or

2. non-licensed individuals who have met the State Division of Mental Health's training standards for case managers and who are supervised by a licensed mental health professional listed in section E-1 above.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Utah

CASE MANAGEMENT SERVICES

A. Target Group

Targeted case management services are provided to Medicaid eligibles who:

1. reside in a Salt Lake, Summit, Wasatch, Weber or Utah County emergency homeless shelter capable of providing temporary shelter for at least 30 days in order to assure that sufficient case management services are provided to successfully reintegrate the homeless into the community; and

   a. do not otherwise have a permanent address or residence in which they could reside; and

   b. do not live in a boarding home, residential treatment facility which houses only victims of domestic abuse; and

   c. are not receiving targeted case management services as part of another approved target group; or

2. have left the homeless shelter; and

   a. require continued targeted case management services to prevent a recurrence of homelessness; and

   b. are not receiving targeted case management services as part of another approved target group.

The need for case management services will be identified by the qualified provider in the recipient's needs assessment.

B. Areas of State in Which Services Will be Provided

/ / Entire State

/X/ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide: Salt Lake, Summit, Wasatch, Weber and Utah counties)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Utah

C. Comparability of Services

/ / Services are provided in accordance with section 1902(A)(10)(8) of the Act.

/X/ Services are not comparable in amount, duration and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services

Targeted case management services are a set of planning, coordinating and monitoring activities that assist recipients in the target group to access needed housing, employment, medical, nutritional, social, educational and other services to promote independent living and functioning in the community.

Covered case management activities include:

a. assisting the recipient to determine need for services and developing a service plan to assure adequate access to necessary services and community resources;

b. advocating for and linking the recipient with required services and community resources identified in the service plan;

c. assisting the recipient to acquire necessary independent living skills;

d. coordinating the delivery of services including coordinating with the hospital and nursing facility discharge planner in the thirty-day period prior to the recipient's discharge to the homeless shelter. (This is the only case management service provided to hospital or nursing facility inpatients and is limited to a maximum of three hours per patient per year. Case management services will not be provided to individuals between the ages of 22 and 64 who are inpatients in institutions for mental disease);

e. monitoring to assure the appropriateness and quality of services delivered and to assess the recipient's progress and continued need for service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Utah

E. Qualifications of Providers

Qualified case managers include:

1. licensed physician, licensed psychologist, certified or clinical social worker, registered nurse, licensed marriage and family therapist or licensed social service worker who is available to provide comprehensive case management services on a 24-hour a day basis to ensure the homeless individual's successul reintegration into the community; or

2. non-licensed individuals who are supervised by one of the licensed qualified providers listed in section E-1 above.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.